



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

THIRD COAST EMERGENCY PHYSICIANS
PO BOX 2283
MANSFIELD TX 76063

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-12-1235-01

MFDR Date Received

DECEMBER 21, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Pt presented to the Emergency room after a fracture to the tailbone which happened at work. Claim has denied as not an emergency."

Amount in Dispute: \$182.74

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Review of the documentation from the DWC-60 packet does not support an emergent admission. As such no payment is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 24, 2011	CPT Code 99284	\$182.74	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2, effective July 27, 2008, defines a medical emergency. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- CAC-W1-Workers compensation state fee schedule adjustment.
- 899-Documentation and file review does not support an emergency in accordance with Rule 133.2.
- CAC-193-Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.
- 724-No additional payment after a reconsideration of services.

Issues

1. Does the documentation support a medical emergency? Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied reimbursement for the disputed emergency room services based upon reason code "899."

The requestor states in the position summary that "Pt presented to the Emergency room after a fracture to the tailbone which happened at work. Claim has denied as not an emergency."

The respondent states in the position summary that "Review of the documentation from the DWC-60 packet does not support an emergent admission. As such no payment is due."

28 Texas Administrative Code §133.2 (3) defines "Emergency--Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

(i) placing the patient's health or bodily functions in serious jeopardy, or

(ii) serious dysfunction of any body organ or part."

The Division finds that the documentation does not support a medical emergency as defined in 28 Texas Administrative Code §133.2 (3); therefore, the respondent's denial of reimbursement based upon reason code "899" is supported. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

8/22/2013

Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.